THE TEACHING OF CHILD PSYCHIATRY IN PEDIATRICS

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Almost everyone who knows them agrees that child psychiatry and pediatrics are well suited to each other. In fact, many have proposed that they should not only live and work together, but that the relationship should be made legitimate and they should be wedded. The principals themselves have indeed, off and on, wooed each other, but the resulting engagements have not always been stable. Part of this stems from the problem of identity. They have not always been clear as to which one would be the bride and which the groom. However, their need for each other is so great that they have been exploring various patterns of at least trial marriage.

Long before either child psychiatry or pediatrics developed in their present forms, it became apparent that in order to deal with many aspects of child care special kinds of knowledge about the thinking and communication of children were necessary. In 1854, Dr. Charles West, founder of the Hospital for Sick Children in London, told his medical students, "Your old means of investigating disease will here to a degree fail you, and you will feel almost as if you had to learn your alphabet again." Also, it is "as if you were to hear around you everywhere the sounds of a foreign tongue, and to observe manners and customs such as you had never seen before." He then added, "if you are not fond of little children you cannot learn it, for they soon make up

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their minds as to who loves them, and when ill, they will express their real feelings, whether by words or signs, to no one else."

Since then in pediatrics there have been periodic stirrings in the direction of dealing with children's feelings and what goes wrong with them, but it never became an organized body of knowledge and practice in spite of a few attempts by pediatricians such as Czerny (1908), Rachford (1905), and Cameron (1919) to put the problems in book form. That step occurred only with the development of child psychiatry, which grew from the fields of child development, mental deficiency, delinquency, and psychoanalysis, and crystallized as a field of its own in this country with the beginning in the 1920's of pediatric-psychiatric services in three medical schools. The 1930 White House Conference Proceedings on Child Health (1932) marked a concerted move and warning by pediatricians to keep up with the new field. Crothers (1937) followed this with his book, *The Pediatrician in Search of Mental Hygiene,* in which he defined the struggle and often the communication problems of the meeting of the two fields. Brennemann (1931) expressed the pediatrician's cautioning about these moves when he wrote on "The Menace of Psychiatry." In 1930, Adolf Meyer and Edward Park established a child psychiatry unit in the Pediatric Department at Johns Hopkins Hospital, with Dr. Leo Kanner as its first chief.

Since then many different patterns have been attempted to try to make the wedding a fashionable one. The objectives of bringing child psychiatry and pediatrics together have been roughly similar to those of bringing adult psychiatry and internal medicine together. The big difference is that the pediatrician, by definition, *has* to deal with the problems of growth and development, and in this context the problems of physical and personality development cannot be separated. However, the ability to learn the children's alphabet, manners, and customs, about which West told his students, varies widely from pediatrician to pediatrician. There are many kinds of people who are pediatricians and many reasons why doctors become pediatricians. Not all the reasons leave the way open to insights about the crises of emotional development. Therefore, to reach all the pediatricians, especially those in training, there have developed many different approaches to teaching the applicable information that is available from the body of knowledge developed within the framework of child psychiatry. Many

different kinds of people from child psychiatry have been involved in this liaison type of teaching. Obviously none of the patterns evolved has provided the complete answer; not every format is suited to all teachers and all students. A brief review of the patterns and types of people involved seems worth while.

The first liaison movement came from pediatrics itself, when a few pediatricians in the 20's and early 30's, becoming aware of psychoanalytic thinking and taking note of the earliest child guidance clinics, joined these "new" fields. In the mid-30's the Commonwealth Fund selected a few pediatricians and provided training in child psychiatry for them. Some of the people involved in these two movements elected to retain their identities as pediatricians, others became child psychiatrists or what has come to be known as pediatric psychiatrists. There followed a movement which alarmed child psychiatry. These psychiatrically oriented pediatricians and pediatrically oriented child psychiatrists began to train others in the same pattern and to work within pediatrics. However, only a few stayed in pediatric teaching; most of the others began to practice child psychiatry. More recently in most medical school settings the pediatric services have tended to invite the faculty child psychiatrist to participate with them. A few have elected to have as their own consultant a child psychiatrist functioning as a member of the pediatric department. Others share the child psychiatrist by offering joint appointments in pediatrics and psychiatry, or have the child psychiatrist assigned from the department of psychiatry to pediatrics.

The child psychiatrist in turn has brought into the teaching setting the clinical psychologist, and the psychiatric social worker—members of the usual clinical team. Where there are either no child psychiatrists, uninterested child psychiatrists, or child psychiatrists who are too busy, other disciplines have been brought into pediatrics without psychiatric supervision, and a kind of respectability seems to rub off on these ancillary psychiatric personnel by default. However, the relatively new departments of medical psychology have established an important place for themselves in such teaching. Lately, in some settings, the child development specialist has been added to the pediatric psychiatric team. Where there are no child psychiatrists on the faculty, certain schools have made use of child guidance clinics in the community.

The methods in common use for psychiatric participation in pedi-

atric services, as I have said, are many and varied. Recognizing that these variations and combinations in method are to be found in different teaching centers, I have listed them with occasional comment.

Patterns of Teaching

1. *Lectures.* These usually cover basic personality development, treatment of common developmental crises, common psychopathological syndromes, and interviewing techniques. Where there are only these didactic approaches, with or without case demonstrations, this approach is enjoyed by those pediatric trainees who prefer an intellectual approach to emotional problems. Of course, there are some who can go no further than this, because they become too anxious with greater involvement.

2. *Using Pediatricians' Own Cases as Teaching Material.* (a) Pediatric Outpatient Consultation. The child psychiatrist is called in to give on-the-spot examination, opinion, and treatment ideas. Some have the child psychiatrist present on certain days, or at a specific hour in the day, and cases are "saved up" (Langford & Wickman, 1948). The latter patterns allow the case to be turned over to the child psychiatrist without the pediatrician's remaining involved, unless safeguards are established.

(b) Ward Consultation. The child psychiatrist may be called in on consultation as needed; this then may or may not involve the referring pediatric trainee. In other settings, the child psychiatrist makes rounds with the pediatric and surgical staffs; this provides for optimal communication. Another variation is to have child psychiatry rounds on pediatric wards a few times a week with grand rounds weekly—an effective method if the pediatric staff attends.

(c) Well-baby-clinic Participation. Here the child psychiatrist usually is a consultant. Ideally, he should be involved with the whole staff of the clinic in preventive psychiatric or anticipatory guidance approaches. If there is to be a true primary preventive program in psychiatry, it must be with the age group served by these clinics. If properly oriented, the pediatricians seem to offer the logical front-line approaches to prevention. In some areas this has already been quite effective. For example, there are now many fewer feeding and toilet training problems than there used to be in well-baby settings. One

must be careful here to avoid the pattern of teaching pediatric trainees formulae for dealing with each symptom encountered. Instead of seeking for simple formulae and stereotypes to cope with the problems of early personality development, rather the pediatric trainee should be encouraged to look under the surface for determinants of behavior.

3. *Family Care Plans.* In some medical schools much of the orientation of the pediatric trainee and staff members is accomplished via joint participation with child psychiatrists and others in family care programs. This approach has the advantage of providing opportunity for enhanced communication between the disciplines. The social worker can function as a coordinator, clarifier, and sounding board, and can call attention to distortions or conflicts which develop in the trainee's thinking over differing orientations or points of view.

4. *Visual Aids (movies and pamphlets).* A wide range of such devices is available and can save a good deal of lecturing. However, the value of visual aids as effective teaching devices has been severely questioned in the recent Pennsylvania Mental Health Association Conference critique of mental health education. In pediatric training, particularly with the trainee who is working with children because of discomfort in working with adults, or because of difficulty in communication, the printed instructions or pamphlets are eagerly used as a device to avoid dealing directly with parents.

5. *Panel Teaching.* The child psychiatrist in some schools is brought into a multidisciplinary medical team, including the basic sciences, to present a rounded body of medical information about a specific subject or clinical pattern. A difficulty encountered in this teaching technique is the lack of opportunity to offer an organized body of information in a discipline such as child psychiatry unless supplementation is available.

6. *Community Services for Children.* Where no organized child psychiatric service is available within the medical school framework, "farming out" of pediatric trainees to community child guidance clinics is a method of creating some awareness of how the other half lives. At least one important objective of teaching child psychiatry to pediatric trainees can be achieved here: learning which cases should be referred to child psychiatrists and how to make such referrals. Also in such settings instruction is available for the trainee in interviewing techniques, as well as the concept of team functioning. However, usu-

ally the child guidance clinic, like the residential treatment center, deals with a level of psychopathology that the pediatrician will not generally meet in practice.

One invaluable experience for the pediatric trainee is contact with the Public Health Mental Health Services, including mental retardation clinics and institutions, and other community child care programs, such as the mental health aspects of school health, convalescent care, the crippled children's program, as well as child placement and adoption patterns.

7. *Rotating the Pediatric Trainee Through the Child Psychiatry Services.* This is a method which is felt to be an approach of choice in those of the teaching settings which have used it properly. The worry of some pediatric teachers is, as mentioned, that the trainees will go on to become child psychiatrists. However, experience shows that if four to six months of full time or three-fourths time is allowed for such assignment, the pediatric trainee is able to have a useful experience and still maintain his primarily pediatric orientation. The key to success or failure of such an approach, and what makes this different from the other teaching approaches, is individual and group supervision of diagnostic and treatment cases carried by the trainee. There are many who feel that such a nonpsychiatric trainee should not be exposed to treatment of emotional problems, even if concentration is on the more superficial ones which the pediatrician could be expected to handle in practice. However, aside from the other objectives to be mentioned, there are few more effective ways to help the trainee develop awareness of his own reactions to patients and parents and the influence of such reactions upon what happens to his patients. Medical learning involves identification with the teacher, and the process of supervision allows greater opportunity for identification with the patterns of thinking available in child psychiatry.

There are few other approaches which can better impress a trainee with the manifestations of drives and the unconscious phenomena, the nature of defenses and their constantly shifting patterns, as Bibring (1960) points out, including regression and flight to health. There are few other teaching methods which make available, hopefully for some modification, these individual personality aspects of the pediatric trainee which not only can get in the way of effective dealings with children and families, but could even be destructive. Examples are

residents who are punitive to mothers, or have to prove constantly that they can do better with children than the mothers, or who confide proudly that they do rectals on all their hospital patients, and without gloves.

8. *Child Development Programs.* Firsthand experience with the developmental problems of the normal, not necessarily the sick, child is an advantage not only for the child psychiatrist but also for the pediatrician. Having a nursery school in the medical school framework, or an affiliation with a nursery school, provides a natural setting for such involvements. A growth and development clinic jointly manned by a pediatrician and a child psychiatry clinical team, in which trainees study and present for discussion problems of distortions in physical and emotional growth, has been an effective technique of training in both fields.

9. *Postgraduate Courses for Pediatricians by Child Psychiatrists.* While such courses are usually established in medical school settings for practicing pediatricians, they most often are open to include the pediatric trainees. These courses take multiple forms; the most usual is to have a one-, two-, five-, seven-, or fourteen-day course or "institute." The institutes often include didactic approaches which may or may not be followed by small group discussions. The shorter courses may highlight a specific area in the field of child psychiatry as it applies to pediatrics. The one- or two-week courses tend to cover the range of personality development with discussions on the handling of common problems. Joint sponsorship of such courses by the American Academy of Pediatrics has become fashionable. Usually in these endeavors child psychiatrists are joined on the faculty by psychiatrically oriented pediatricians.

The value of such training courses has been questioned since the results are so variable. They serve the greatest purpose for groups of pediatricians who during training have not had much orientation in child psychiatry. For others, the institute serves as a type of refresher. One must watch, however, for the tendency of such courses to be dominated, particularly in the discussions, by "students" who come with special problems or because of special problems, not infrequently in their own families. Here, too, the tendency to find intellectualized answers to problems needs to be de-emphasized.

A few new variations on this theme have been experimented with

recently. For example, when there is emphasis in such a course on interviewing techniques, the "student" actually conducts interviews following the course of instruction, which are then discussed by a supervisor or in a group. Another variation is to have the child psychiatrist participate in pediatric courses.

Still another approach which has been successfully used in a few communities is the establishment of a weekly or semimonthly seminar throughout the year in which pediatricians present the problems with which they are dealing to a child psychiatrist or a faculty of child psychiatrists. These seminars tend to reach pediatricians who already have enough interest and awareness to make investment in such training.

10. *The Child Psychiatrist As the Consultant to Practicing Pediatricians.* This is a device, utilized successfully by Dr. Robert Stubblefield, in which a faculty child psychiatrist meets on a regular basis with a group of pediatricians to discuss their handling of a group of cases which are presented either for consultation or serially on a type of continuing case seminar basis (Stubblefield & Martin, 1961). This may very well be a logical pattern which will be increasingly used in the future.

Objectives and Content of Psychiatric Teaching in Pediatrics

One must think in terms of very limited objectives as the baseline for what can be accomplished with all pediatric trainees; with the individual who has a greater capacity to deal with psychodynamic formulations and has the capacities for awareness which allow for greater insight into children and parents' behavior and interaction, it is possible to go much further.

It is almost axiomatic in dealing with pediatric trainees that the communication system we are used to in psychiatry has to be modified. We get further by demonstrating behavior and thinking that is out of a patient's awareness, instead of unconsciously determined. We cannot talk about castration anxiety and have most of them with us, but we can talk about fear of bodily hurt which they see every day. Also, if we can translate our concepts of pathology into terms used to deal with physical disease, they can follow us much more easily.

It is expected, at least in more enlightened pediatric training curricula, that the basic information about personality growth and development is covered; additional basic objectives for all pediatric trainees can be structured in the following manner.

1. *Interviewing and Interpretive Techniques with Both Child and Parents.* How does one explore the areas with parents and children that will provide the necessary information to make a formulation as to what is going on? What does one talk about to a child and what kind of technical approaches are available to the pediatrician, both for interviewing and his everyday handling of children? Just as important, but only too often overlooked in training, is instruction in the art and technique of effective interpretation. This is an area important to the pediatrician in handling not only behavioral distortions, but also his presentation to parents of findings and advice in any illness or crisis.

2. *Individualization of Problems.* The ability to individualize both patient and parents runs counter to many of the medical teaching techniques learned by the trainee early in his training where the tendency is to generalize and deal with stereotypes of disease entities. It is especially important to help the pediatric trainee recognize and deal effectively with some of the more common defense patterns of parents that can obstruct the development of the cooperation needed between doctor and family in treating any disease successfully, but particularly in treating long-range crippling diseases, such as cerebral palsy, mental retardation, blindness, etc. Those defenses which are most often helpful to recognize are denial, avoidance, withdrawal, and projection, as well as those parental responses determined by guilt or passivity. The better technical breakdown of these emotional walls adds immeasurably to the effectiveness of the pediatrician's work with families.

3. *Observation.* The pediatric trainee can benefit greatly and save much diagnostic time by learning the clues to what, besides physical signs, there is to see in his child patients and in parent-child interactions. This approach involves particularly training in the meaning of nonverbal phenomena and communication.

4. *Transference Phenomena.* The recognition by the pediatric trainee of the influence of his attitudes, tones of voice, and his nonverbal behavior upon children and parents is a great asset, particularly if the trainee can be helped to bring such awareness of himself to his dealings with patients.

5. *Defining What the Pediatrician Can Handle.* This involves: (a) a recognition of those emotional problems which have medical consequences, particularly of a psychosomatic nature, as contrasted with those problems which result from emotional concomitants of medical and surgical problems and procedures. (b) The pediatric trainee sorely needs the ability to evaluate when symptoms are part of normal development and when they assume psychopathological significance. Until this type of clinical understanding of behavioral manifestations and thinking disturbances can be developed, the pediatrician cannot define for himself what he can handle in his own practice and what he should turn over to the more specialized services for children. (c) The impact on the family of illness, whether it is psychically determined, physically based, or both, is important for the well-trained pediatrician to have within his awareness.

6. *Prevention.* If there is to be any true prevention of personality disorders, whether on a primary or secondary level, the pediatrician will be in the front line of recognition and planning for dealing with the problems even if he may not be in a position to deal with them himself. The basis for anticipatory guidance should be a part of the pediatric trainee's body of information and practice; for this, it is necessary for him to have more than just an intellectual knowledge of personality growth and development.

7. *Technical Approaches.* There have been developed within the framework of child psychiatry technical approaches which can be very useful to the pediatrician, such as Levy's (1959) development of a joint, or combined, physical and psychiatric examination of a child. In carrying out approaches and procedures, the ability to individualize is important: the stages, and therefore the concerns, of the child at any specific point in development should be carefully considered. In this way the pediatric trainee can be helped with the problem of maintaining trust and affection in the child toward the doctor who hurts him. There also is technical "know-how" involved in how a pediatrician makes a referral for psychiatric diagnosis or treatment so that it can be accepted.

Future Objectives

If one can project some of the present trends of this liaison between child psychiatry and pediatrics, one sees the recognition on the part

of practitioners in both fields that they really have common origins. In fact, one of the difficulties in the way of a successful marriage is that they are really half-brother and sister. It is anticipated that in the future the lines of demarcation will become less and less marked. It can be hoped that the psychiatric techniques of observation and communication can be made part of the teaching of physical diagnosis in pediatrics, as an extension of what else there is to see and hear.

It is anticipated that the trend will be reversed and that the pediatrician, as well as the child development specialist, will be called on increasingly to train the child psychiatrist. In other words, as the constitutional bases for personality are better defined and the role of individual constitutional differences comes to be more commonly included in the child psychiatrist's formulations about children, there will be an increasing use in the training of the child psychiatrist of the body of information available from pediatrics. For example, the organic components of the ego are better defined for child psychiatry as the result of Richmond's study of infant patterns of response now being conducted at State University of New York in Syracuse.

Increasingly the child psychiatrist will be coming to the pediatric center for training. He will be involved in the well-baby clinic, the convalescent home, and the rehabilitation services for children from the new horizons they are developing. Pediatric specialties which can contribute to the training of the child psychiatrist include biochemistry, genetics, neurology, and neurophysiology. The sounder the grounding of the child psychiatrist in information about the constitution, the firmer will be his foundations.

The information coming from the other behavioral sciences, particularly anthropology and sociology, will have a greater impact on child psychiatry. These influences will, in turn, be related to pediatric practices, and usable knowledge about cultural differences will become part of the pediatrician's armamentarium.

Standards will be established in both pediatrics and child psychiatry which will better demarcate the individuals who are qualified to handle the time-consuming work on the deeper levels of psychopathology. There will be less and less room in the field as more competent people are trained for the "prematurely born" pediatric psychiatrist, or the "illegitimately born" who may or may not turn out successfully. This improvement will require preventive measures in our own fields

as we encourage not only the development of better standards, but the participation by pediatricians in the development of child psychiatry standards and the inclusion of child psychiatrists in the development of pediatric standards.

It is anticipated that the next direction in which the joint effort of both fields will need to make its strongest advances is the area of primary prevention of emotional difficulties. It is in this area that there is the greatest need and hope for effective collaboration in the future.

In general hospitals where there are pediatric services, we might look for the inclusion of provisions for hospitalization of children with emotional difficulties requiring relatively short periods of study or treatment under controlled conditions. We will need to restructure some of the hospital architectural plans, especially for pediatric services, as well as the training of nursing personnel and other ancillary child care personnel to function on diagnostic and treatment teams.

It is anticipated that as the ties between the two fields become firmer and clearer, with more effective teaching and training as a result, more funds should be made available, not only for the collaborative teaching approaches, but also for collaborative research, particularly in the area of prevention.

It has been said that the future of child psychiatry is in pediatrics. I think it is evident from this discussion that the converse also holds true, that the future of pediatrics is also partly in child psychiatry. In other words, deny it as they will, they cannot get along without each other.

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